



IDAHO DEPARTMENT OF
HEALTH & WELFARE

COPY

C. L. "BUTCH" OTTER, GOVERNOR
RICHARD M. ARMSTRONG, DIRECTOR

DEBBY RANSOM, R.N., R.H.I.T. – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888

September 4, 2009

Thair Pond
Tomorrow's Hope - Navarro
1655 Fairview Avenue, Suite 100
Boise, ID 83702

RE: Tomorrow's Hope - Navarro, Provider #13G061

Dear Mr. Pond:

This is to advise you of the findings of the Medicaid/Licensure survey, which was conducted at your facility, Tomorrow's Hope - Navarro, on September 3, 2009.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, which states that no Federal deficiencies were noted at the time of the survey.

Also enclosed is a Statement of Deficiencies/Plan of Correction form listing State Licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.
2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.
3. Identify the date each deficiency has been, or will be, corrected.
4. Sign and date the form(s) in the space provided at the bottom of the first page.

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **September 17, 2009**, and keep a copy for your records.

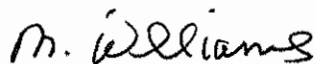
You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

<http://www.healthandwelfare.idaho.gov/site/3633/default.aspx>

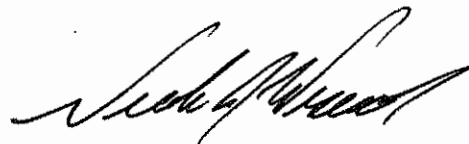
This request must be received by September 17, 2009. If a request for informal dispute resolution is received after September 17, 2009, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,



MONICA WILLIAMS
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MW/mlw

Enclosures



TOMORROW'S HOPE

1655 FAIRVIEW AVENUE, SUITE 100
BOISE, ID 83702

PHONE: (208) 319-0760
FAX: (208) 319-0765

Monica Williams
Health Care Surveyor
Non-Long Term Care
Bureau of Facility Standards
Department of Health and Welfare
PO Box 83720
Boise, Idaho 83720-0036

RECEIVED
SEP 11 2009
FACILITY STANDARDS

September 9, 2009

RE: Navarro Statement of Corrections

Dear Ms. Williams,

Please find attached our Statement of Corrections for deficiencies found during your recent survey of our Navarro Home.

We consider the survey process part of our Quality Assurance program and will make every effort to correct deficiencies found.

If you have any question, please contact me at the above numbers.

Sincerely,

Thair Pond
Administrator


Inc
CC. file, Navarro

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/04/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/03/2009
NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - NAVARRO			STREET ADDRESS, CITY, STATE, ZIP CODE 946 NORTHWEST 12TH MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 000	<p>INITIAL COMMENTS</p> <p>Tomorrow's Hope - Navarro is in compliance with the requirements of 42 CFR 483 Subpart I, Conditions of Participation: Intermediate Care Facilities for Persons with Mental Retardation.</p> <p>The survey was conducted by: Monica Williams, QMRP</p>	W 000			

RECEIVED
SEP 11 2009
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE **Thair Pond, Administrator** (X6) DATE **09/09/09**

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/03/2009
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M 000	16.03.11 Initial Comments The following deficiency was cited during the licensing survey. The survey was conducted by: Monica Williams, QMRP	M 000	<p>RECEIVED SEP 11 2009 FACILITY STANDARDS</p> <p>MM380</p> <p>Vents replaced</p> <p>Floor check to ensure safe and meets conditions of repair and safety. Problems noted will be corrected.</p> <p>Para Q and Maintenance responsible by</p>	10/01/09
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept clean and in good repair for 7 of 7 individuals (Individuals #1 - #7) residing in the facility. The findings include: During an environmental survey conducted on 9/3/09 from 9:30 - 10:00 a.m., the following concerns were noted: - The floor between the refrigerator and dishwasher was notably sunken and moved when stepped on. - The floor vent in the dining room contained dirt and food debris. - The vent below the kitchen sink cabinet was covered with rust.	MM380		

Bureau of Facility Standards

Thair Pond, Administrator 09/09/09/

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE